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ABSTRACT

Deafness often leads to unnecessary communication deficits which produce developmental deviations in the psychological development of children. These deviations mesh with environmental frustrations and with a continuing lack of reciprocity in human relationships to produce psychopathological symptoms. The primary intervention in work with deaf children is educational: the children and parents must be provided with multimodal communication (visual, aural, and tactile) in order to foster normal psychological development. Mental health professionals can contribute to this process as they work with parental reactions to the diagnosis of deafness (anger, guilt, mourning) which frequently interfere with the development of normal parent-child relationships. (Author)

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PREVENTION OF SOME COMMON DEVELOPMENTAL DEVIATIONS ASSOCIATED WITH DEAFNESS: THE CONTRIBUTION OF THE MENTAL HEALTH PROFESSIONAL*

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Deaf people are not often mentioned and still less frequently heard at professional meetings; neither this APA nor the other are exceptions to this rule. This is not because deaf people have nothing to tell us; nor is it because deaf people are somehow immune to the problems of living and of mental health which are of concern to the clinicians amongst us.

Deaf people are not heard at meetings like this one because of a history of educational segregation which has left most deaf people with a greatly-impaired ability to use the daily language of hearing people and has left hearing people with--in most cases--almost no ability to use the daily language of deaf people. And there we stand, facing each other, unable to communicate.

A clinician and a patient must be able to communicate if they are to understand each other. This is the first barrier encountered in clinical work when a hearing clinician meets a deaf patient. There are various ways around the barrier or over

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the barrier, but it is impossible to ignore the barrier. A person skilled in clinical psychology who cannot communicate with a deaf patient is no more in a position to make an accurate diagnosis or to provide effective treatment to that deaf patient than is a person who is skilled in sign language and knowledgeable about deafness but who knows nothing of clinical psychology.

In our work at the University of California Center on Deafness in San Francisco we have found that, once we have managed to circumvent some of the communication barriers presented by our patients, they appear to be just about as imaginative in their symptoms and difficulties as are hearing people. There is a wide variability in diagnoses which spans the range of the official nosology.

The handout sheets which have been distributed amongst you summarize diagnoses encountered at our Center during two different periods of time. They also include similar statistics for inpatient programs at Rockland State Hospital in New York (Altshuler, Rainer, & Deming, 1978) and at St. Elizabeth's Hospital in Washington, D.C. (Robinson, 1978).

Insert Tables 1 and 2 about here.

At the same time we have found that we have more than our share of people who appear to have experienced significant deficits and/or deviations in their psychological development. These developmental deviations appear to "explain" the prevalence of what might be termed "behavior disorders" or "personality disorders". The "immature", "impulsive", and "egocentric" deaf patient is well-established in the psychiatric literature (Rainer & Altshuler, 1966; Schlesinger & Meadow, 1972). However, we believe that we must qualify our remarks about "immaturity", "impulsivity", and "egocentricity" in the deaf with the following observations:

1) our patients, by and large, have been subjected to more frustration than is encountered in the "average expectable environment"; and

2) our patients, because of their difficulties in communication, experience great problems in the establishment of reciprocal relationships with both their immediate families and the wider social environment. As a result they lack some opportunities for the formation of identifications, for education, and for socialization.

The label "impulsive" must be interpreted in the light of these observations. From an internal, psychodynamic point of view it is one thing to be "impulsive" when development

has included good early reciprocal relationships between parents and child which have led to stable identifications and to the acceptance of parental and social values. It is quite another thing to be "impulsive" when early parent-child relationships have been distorted by fear, anger, guilt, and grief--all of which are then magnified (in the case of most deaf children) by the frustrations experienced in communication. And, of course, the problems in communication interfere with the creation of healthy identifications and with the appreciation and acceptance of parental and social values.

Our experience is this: When deafness interferes with communication it also interferes with emotional development. The resultant deviations usually represent a compromise amongst the individual deaf person, his (angry or guilty or depressed) parents, and his simultaneously over-frustrating and over-protective school.

These deviations are serious; they show up in many different indices of adjustment (school achievement, referral for psychological services, income, divorce, etc.) and they are difficult to remedy once they have left their mark.

At the same time these deviations are not a <u>necessary</u>

consequent of deafness; as Dr. John Rainer has said so well,

> There are . . . enough observations of the relatively advanced and flexible development of object differentiation, object constancy, and object relationships of the deaf child who has had deaf parents, as compared to the average deaf child with hearing parents, to suggest that it is the parent-child relationship which is important rather than the use of verbal speech as such. (Rainer, 1976, p. 126)

Research done by Dr. Kathryn Meadow more than ten years ago demonstrated that deaf children of deaf parents--that is, deaf children who were able to communicate easily and effectively via sign language with their parents from their earliest years--did better than deaf children of hearing parents--who did not use sign language--on measures of social, communicative, and intellectual development (Meadow, 1968). Our Center is now conducting a follow-up of Dr. Meadow's sample in young adulthood and we look forward to the time when we can share our findings with you. It may be that the differences between the two groups remains relatively stable; it is also possible that the gap will decrease as deaf children of hearing parents become more integrated within the deaf sub-culture which, generally speaking, provides them with most of their opportunities for truly reciprocal effective relationships in adult life.

I suspect that Dr. Denton will have more to say to you later this afternoon about the recent changes in educational philosophy which are finally, after a century of prohibition, allowing deaf people to use all of their sensory abilities in establishing communicative links with their parents, family, and friends. As these links proliferate, and as deaf children learn more about the thoughts and feelings of other people (both hearing and deaf), they will develop the kind of social sensitivity and self-control which has been lacking so often in the past. While this will not put an end to their need for mental health services, it will reduce the frequency and severity of the developmental deviations about which I spoke earlier.

As you have certainly understood by now, it is our position that the most direct and potentially helpful intervention, as far as the emotional and cognitive development of deaf children is concerned, is and will remain an educational one: The provision of both deaf children and their parents with the flexibly, multi-modal communication which must be present in order to develop healthy, reciprocal relationships. However, this intervention cannot be accomplished by educators alone. This is because many hearing parents of deaf children (as well as many educators of the deaf themselves) have strong resistances to the use of any modes of communication other than the usual oral/aural one. These resistances are based upon

their very natural wishes to deny the extent of their deaf children's handicap.

Sensitive interventions by mental health professionals at the time of the diagnosis of deafness can limit such parental denial and can ensure that the usual parental reactions of anger, guilt, and mourning do not destroy the possibility of healthy, reciprocal relationships between the deaf child and his parents. Here the work of the mental health professional who is knowledgeable about deafness can be especially effective and rewarding. It is through programs in early intervention which combine the expertise of the physician, the audiologist, the educator, and the mental health professional that we shall achieve our goal: That every deaf person should be able to face the demands of life with a solid core of human relationships and experience. Deaf people will certainly still have their problems; but they will also be able to communicate about them with their family, their friends . . . or even their therapists. And, if the hearing people involved have developed their own communicative skills, the deaf people will (hopefully) have the feeling that they are heard and understood.

References

Altshuler, K.Z.; Rainer, J.D.; & Deming, W.E. Mental health and the deaf: A first step toward epidemiology. In Mental Health in Deafness, Experimental Issue No. 2. Washington, D.C.: St. Elizabeth's Hospital, National Institute of Mental Health, 1978.

Meadow, K.P. Early manual communication in relation to the deaf child's intellectual, social, and communicative functioning. American Annals of the Deaf, 1968, 113, 29-41.

Rainer, J.D. Observations on affect induction and ego development in the deaf. International Review of Psycho-Analysis, 1976, 3, 121-128.

Rainer, J.D. & Altshuler, K.Z. Comprehensive mental health services for the deaf. New York: Department of Medical Genetics, New York State Psychiatric Institute, Columbia University, 1966.

Robinson, L.D. Sound minds in a soundless world. Washington, D.C.: St. Elizabeth's Hospital, National Institute of Mental Health, 1978.

Schlesinger, H.S. & Meadow, K.P. Sound and sign: Childhood deafness and mental health. Berkeley: University of California Press, 1972.

TABLE 1: Psychiatric diagnoses of outpatients seen at the University of California Center on Deafness, 1968-1971 and 1974-1978.

Diagnosis	DSM #	1968-71*	1974-78
Maladjustment without manifest psychiatric disorder	316	5 (4.3%)	10 (10.8%)
Adjustment reactions	307	21 (17.9%)	27 (29.0%)
Behavior disorders	308	37 (31.6%)	11 (11.8%)
Personality disorders	301	20 (17.1%)	22 (23.6%)
Neuroses	300	5 (4.3%)	11 (11.8%)
Psychoses	295	26 (22.2%)	10 (10.8%)
Others		3 (2.6%)	2 (2.2%)
Totals		117	93

*from Schlesinger, H.S. & Meadow, K.P. Sound and sign: Childhood deafness and mental health. Berkeley: University of California Press, 1972, pp. 242-243.

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TABLE 2: Psychiatric diagnoses of inpatients seen at the programs for the deaf at Rockland State Hospital (New York) and St. Elizabeth's Hospital (Washington, D.C.).

Diagnosis	DSM #	Rockland*	St. Eliz.**
Maladjustment without manifest psychiatric disorder	316	4 (2.5%)	N/A
Adjustment reactions	307	17 (10.6%)	52 (34.7%)
Behavior disorders	308	3 (1.9%)	2 (1.3%)
Personality disorders	301	17 (10.6%)	9 (6.0%)
Neuroses	300	5 (3.1%)	25 (16.7%)
Psychoses	295	88 (55.0%)	44 (29.3%)
	296, 297, 298	9 (5.6%)	N/A
Others		17 (10.6%)	18 (12.0%)
Totals		160	150

*from Altshuler, K.Z.: Rainer, J.D.; & Deming, W.E. Mental health and the deaf: A first step toward epidemiology. In Mental Health in Deafness, Experimental Issue No. 2. Washington, D.C.: St. Elizabeth's Hospital, National Institute of Mental Health, 1978, p. 20.

**from Robinson, Luther D. Sound minds in a soundless world. Washington, D.C.: St. Elizabeth's Hospital, National Institute of Mental Health, 1978, p. 95.

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